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ABSTRACT

Current approaches to need assessment belong to one of three theoretical orientations: the rationalistic perspective in which need is predicated on the existence of some pathology or deviance from the rational ideal; (2) the empirical position where need is conceived as deviance from a normative or observed state of good health and well-being; and (3) the relativistic orientation which derives need statements from the socio-cultural-political consensus that emerges from the community. The following definition of unmet need for health and human services is offered as capable of overcoming the conceptual and operational deficiencies that exist among current definitions of needs: An unmet need is said to exist when a problem in living, a dysfunctional somatic or psychological state, or an undesirable social process is recognized, for which a satisfactory solution requires a major mobilization of additional resources and/or a major reallocation of existing resources. There is a need to distinguish need assessment--an environmental monitoring system--from program evaluation. The latter is an internal monitoring system that assesses the achievement of the program in terms of goal and mandates. Both systems, however, are significantly interdependent processes that are essential for efficient program planning. (Author)

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THEORETICAL ISSUES IN DEFINING AND IDENTIFYING HUMAN SERVICE NEEDS

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This paper (a) examines assumptions that underlie need identification and assessment methodologies; (b) evaluates the adequacy of existing definitions of "need" as they relate to a comprehensive need assessment program; (c) presents a definition of need and discusses the implications of this definition for comprehensive need assessment; and (c) compares and contrasts need assessment with program evaluation.

I. APPROACHES TO AND PROBLEMS IN DEFINING HUMAN SERVICE NEEDS

Existing need assessment strategies such as epidemiological descriptors analysis, social indicator analysis, and citizen survey can be interpreted in terms of three theoretical orientations: Rationalistic, empirical, and relativistic. This classification of need assessment strategies is not intended to be all-inclusive, but is rather offered as a framework within which to begin thinking about needs assessment in a more concise and critical way.

First, rationalists posit a rationally determined ideal state of affairs against which situations are judged. From this perspective, need for health and human services is predicated on the existence of some pathology or deviance from the rational ideal. Discordance from the ideal can be either ecological, social, psychological, or

physiological in symptomatic manifestations and etiology. The major instrumentality employed to identify or anticipate divergence from ideal conditions is epidemiological descriptors (i.e., symptoms and their prevalence or incidence). Because the documentation of epidemiological descriptors is a highly technical enterprise, the responsibility for identifying and forecasting needs for services is entrusted with professional service providers and related experts (cf. Lemkau, 1967). Other needs assessment approaches that rely on the political, social, and economic processes such as consumer demand and consumer advocacy received little attention from the rationalists. It should be noted, however, that the rationalistic position has strongly influenced and systematized the needs assessment fields. Its methodology is highly developed technically and many currently favored strategies (e.g., social indicators analysis) derive from it.

Considering next the <u>empirical</u> orientation, adherents to this position accept the premise that need for health and human services is best conceived as <u>deviance from a normative or observed state</u> of good health and well-being. Advocates of the empirical position assume that deviance from the normative, observed state motivate individuals to seek services. The major strategy used by empiricists to assess service needs consists in the analysis of demand for services or service utilization. The usefulness of service utilization analysis, however, depends largely on the adequacy and comparability of human service information systems within the community agencies. Of particular concern are the issues of the definition of a "case" (Dohrenwend & Dohrenwend, 1969; WHO, 1960) and the consistency with

which the same set(s) of information are gathered within an agency or across agencies (Henisz, Tischler, & Myers, 1974). Nonetheless, a worthwhile contribution of the empirical orientation has been the recent focus on social-cultural factors that impede or facilitate the translation of wants and desires into demands for services (e.g., Wan & Soifer, 1974; 1975).

Turning finally to the relativistic position, proponents of this position rely on the interplay of interest groups in the community to achieve a kind of socio-cultural-political consensus regarding the level and extent of need for services. Relativists believe that the identification and assessment of human service needs cannot be comprehensive unless the full range of perspectives and values are taken into consideration. Need assessors who embrace this position would like to:

* Bring the widest range of information to bear on the process of assessing needs;
* Assess needs at all levels of social organization; and
* Establish the relevance of needs assessment for planning of services and programs (Nguyen, Attkisson, & Bottino, 1976).

A need assessment predicated on the assumptions of the relativistic position offers the possibility of arriving at the most comprehensive statements regarding the needs for health and human services at each level of community organization. However, it involves a very complex process that has not been fully developed. A conceptual framework that may help us begin to think more concretely about this process is the convergent analysis approach proposed by Siegel, Attkisson, and Carson (in press). As described by these authors:

Convergent analysis usually begins with data that are internal to the service system, such as legal and funder mandates, historical trends relevant to service delivery, and client utilization information. This is the store of data that need assessment often shares with evaluation. But, in addition to it, there is information about the orientation, training and interests of administrators and providers, and the perspectives of advisory and policy board members as well as the viewpoints of citizens. The process then integrates information assembled about a specified social area or target community via a network of techniques designed to capture a wide range of perceptions about conditions in the community.

II. ILLUSTRATIVE EXISTING DEFINITIONS OF NEED

In addition to the three orientations that underlie need assessment strategies, there are also a number of formal statements defining needs. It seems informative to review these definitional statements in order to raise some salient issues that must be considered in our attempts at comprehensive need assessment.

Jeffers, Borganno, and Barlett (1971), after making the distinction between demand, want, and need for medical services, define need as:

> the quantity of medical services which medical opinion believes ought to be consumed [in order for the population] to remain or become as 'healthy' as is permitted by existing medical knowledge (pp. 46-47).

The major implication of defining need in this manner is the exclusion of input on the part of the persons or groups whose needs are to be met or who may be affected by the programs that are implemented on the basis of the assessment process.

> A similar approach is offered by Saunder Lund (1973):
>
> When a circumstance is labeled necessary or desirable by those with control over the organization, a "need" may be said to exist.

According to this definition, the determination of need is the responsibility of organizational control agents. However, as Schaefer (1975, p. 293) has pointed out, "the information available to expert opinion is limited and perhaps imperfectly perceived." Moreover, even if technical information is perfect and available to everyone, laymen as well as service professionals and control agents, the evaluation of that information will still not be unanimous or consistent among those drawing conclusions about the level and intensity of needs for services (cf. Schaefer, 1975, p. 294). Thus, one must question the wisdom of placing the burden and responsibility for needs assessment only on the shoulders of service professionals and control agents.

Wan and Soifer (1974) are less restrictive concerning who is responsible for determining need:

> Need is usually measured by the symptoms of an illness perceived by the individual, his response and evaluation of the disabling effects, or by medical assessment of health status and physician-rated urgency of the condition (Wan & Soifer, 1974, p. 101).

This conceptualization of need is strictly idiographic in that one must consider each instance of need on an individual, case-by-case basis. However, when drawing conclusions for planning purposes, one must identify and assess human service needs at all levels of social organizations, i.e., the individual, the group or family, the organization or social network, the institutional system, the community, and society (Attkisson, McIntyre, Hargreaves, Harris, & Ochberg, 1974, p. 747). Thus, a strictly idiographic conceptualization of need must be considered inadequate for comprehensive human service needs assessment.

Blum (1974) offers the most detailed approach to conceptualizing needs for health services. He enumerates eight aspects of health that must be measured (e.g. prematurity of death, disease, discomfort, etc.) and provides indices that may be used to measure each of these aspects at both the levels of the individual and the community (Blum, 1974, pp. 193, 166-185). Presumably, when all these aspects are measured, one would be in a position to plan effectively for services. The difficulty, however, is that, as Blum himself puts it (p. 227): "Measurements define situations and attitudes convert situations into problems." In other words, the activity of measurement only yields information. This information potentially can be converted into value-based statements of need. Determining the implications of these statements for social and program planning are yet further steps in the process of needs assessment.

Finally, Siegel, Attkisson, and Cohn (1976) view need as a relative concept and consider its definition as depending primarily upon those who undertake the identification and assessment effort.

They define need as:

> ... the gap between what is viewed as a necessary level or condition by those responsible for this determination and what actually exists.

This relativistic conceptual approach is congruent with the present state of affairs in which need assessments are by and large activities that are unrelated to one another. However, this definition fails to specify the explicit criteria and processes for distinguishing between met and unmet needs.

In summary, our examination of approaches to measuring and defining need for health and human services leads us to identify the following four conceptual and operational deficiencies:

1. Exclusive reliance on expert opinion or organizational control agents for determining when a need state exists;
2. Insufficient emphasis on and lack of consideration for need states that transcend the individual level of social organization;
3. Lack of specific operational criteria for determining the existence of a need state and its relevance for social and program planning; and
4. Lack of a systematic framework with which to integrate divergent methodological inputs into the process of need identification and assessment.

III. DEFINITION OF UNMET NEEDS

The following definition is offered as capable of overcoming the above conceptual and operational deficiencies:

> An unmet need is said to exist when a problem in living, a dysfunctional somatic or psychological state, or an undesirable social process is recognized, for which a satisfactory solution requires a major mobilization of additional resources and/or a major reallocation of existing resources.

This definition, stated differently, defines unmet needs contingently upon:

* The recognition of a problem, a dysfunctional somatic or psychological state, or an undesirable social process;
* The judgement that satisfactory solutions are not accessible, are not currently adequate, or do not exist in the community;
* The necessity to reallocate existing resources or to appropriate new resources.

The concept of problem involves (a) a perception of what is, (b) a comparison level, i.e., what should be, and (c) an evaluation of the extent and saliency of the discrepancy between what is and what should be. A problem is recognized on the basis of some systematic process of determining the discrepancy between what exists and what is deemed desirable or necessary. This process involves the participation of concerned citizens, interest and political groups, health and human service consumers and providers, funders, program planners, as well as health and health-related professionals.

A satisfactory solution refers to the activity, program, or service which is viewed as capable of reducing the gap between what actually exists and what is deemed desirable or necessary.

The processes of problem identification and solution determination occur within the value and attitudinal frameworks and perspectives of those who participate in them. Furthermore, there is not a necessary isomorphism, i.e., one-to-one relationship, between the problem and its solution in terms of either their intrinsic natures or the levels of social organization where they occur. For example, individual problems such as alienation may be resolved by actions taken at the family, group, or community level. As another example, economic interventions are sometimes the only meaningful solutions to undesirable social problems.

The assessment of resource is, in our view, the key process in arriving at consensus about the relative priorities among unmet needs. While problems may be defined differently depending upon the value and attitudinal perspectives of the participants, solutions to these problems all require the expenditure or mobilization of resources. Given agreed upon goals and objectives, the major component of social and program planning concerns the deployment of existing scarce resources and the development of new resources.

IV. LINKAGE BETWEEN NEED ASSESSMENT AND PROGRAM EVALUATION

In developing methodologies for collecting, analysing, and integrating information relevant to needs assessment, much effort can be saved if one examines the interrelationship of need assessment with another informational system in health and human service programs:

Program evaluation. It must be emphasized at the outset that need assessment is a conceptually separate and operationally different process when compared and contrasted to program evaluation. Following Broskowski and Attkisson (in press), program evaluation is:

> The process of making reasonable judgments about program efforts, effectiveness, efficiency, and adequacy, based on systematic data collection and analysis designed for used in program management, external accountability, and future planning, with special focus on accessibility, acceptability, availability, comprehensiveness, continuity, and integration of services.

Need assessment, by contrast, is an environmental monitoring system which is designed to measure and make judgments about program relevance, adequacy, and appropriateness. This monitoring system is based on systematic collection, analysis, and integration of information about the needs for health and human services as filtered through multiple levels of societal perspectives and as generated through multiple measurement approaches.

In other words, need assessment information provides a fundamental navigational system for program planning and program modification based on continuous assessment of changing community needs. Program evaluation, on the other hand, is an internal monitoring system that assesses the achievement of the program in terms of goals and [illegible] mandates.

Both systems, however, are significantly interdependent processes crucial to the survival, growth, structural soundness, and smooth functioning of human service programs. Each process consumes [illegible] from the other to [illegible] an information base that is essential

information from the other and each provides an information base that is essential for program planning. Planners need both sets of information and the work of planners will be deficient unless information about needs and program evaluation data are simultaneously available.

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